

City Account No: FA _____

PRINT NAME:

Signature Authorization Form
City of Long Beach Ambulance Billing
Phone # (562) 570-6209 Fax # (562) 570-6783

This form authorizes the City of Long Beach to bill Medicare, your Private Insurance Company and/or your government health benefit program for the ambulance and/or paramedic services provided to you or your dependants. If you choose to pay for these services directly, please make your check or money orders payable to the City of Long Beach. Please send your payment to the address listed below or contact us during normal business hours to make a Visa, Master Card or Visa/Master Debit Card payment. Please fill out this form and return it to us as soon as possible since your insurance cannot be billed by the City of Long Beach until this form is completed and returned to:

City of Long Beach
333 West Ocean Blvd., Lobby Level
Long Beach, CA 90842-0001

Signing this form allows the City of Long Beach to submit the bill to your insurance company; however, you remain responsible for paying the entire balance of your account.

"I request that payment of authorized Medicare and/or other insurance or government health benefits be made either to me or my dependants on my behalf to the City of Long Beach for any services furnished me or my dependants by the City of Long Beach, their agents and employees. I authorize any holder of medical information about me or my dependants to release to the City of Long Beach, the Health Care Financing Administration, (Medicare) and/or any other insurance company, including their agents and employees, any information or documentation needed to determine these benefits or the benefits payable for related services."

"I understand my signature requests that payment be made and authorizes release of medical information necessary to secure payment for the claim. If I have supplemental health insurance coverage, my signature authorizes releasing the medical information to the supplemental insurance company, their agents and employees. This signature authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization is to be considered as valid as an original."

PLEASE COMPLETE THE PATIENT INFORMATION BELOW:

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| Patient Information: Name: Address: Phone #: () Date of Birth: Social Security #: | Primary Insurance: Insurance Name: Claims Address: Phone #: () Member ID#: Secondary Insurance: Insurance Name: Claims Address: Phone #: () Member ID#: |
|---|--|

Signature of Patient (if minor, parent/guardian): _____